

Overseas Building Operations/USAID

Summary of Coverage SOC 1A

GP-299452

Summary of Coverage

Employer: Overseas Building Operations/USAID

Group Policy: GP - 299452

SOC: 1A

Issue Date: September 24, 2004

Effective Date: October 1, 2004

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This is an electronic version of the Summary of Coverage on file with your Employer and Aetna Life & Casualty (Bermuda) Ltd. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life & Casualty (Bermuda) Ltd., or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee of an employer participating in this Plan and you reside outside of the United States or Bermuda.

Your Eligibility Date is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 30 days of continuous service for your Employer, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class.

You and/or your dependents are not in an Eligible Class for coverage if you and/or your dependents have reached age 70.

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 19 years of age.

Any other unmarried child under age 25 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.

Open Choice, and Comprehensive Dental

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- Any other child you support who lives with you in a parent-child relationship.

If you have completed and signed a "Declaration of Domestic Partnership" and the Declaration is acceptable to your Employer, you may also cover as your dependent the person who is the "domestic partner" named in your Declaration.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. Sign and return it to your Employer before your Eligibility Date. If you don't sign and return your form within 31 days of your Eligibility, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Effective Date of Coverage

Employees

Your Eligibility Date is the first day of the calendar month coinciding with or next following 30 days from your date of hire, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class, if by then, you have signed and returned your request form. If you don't sign and return your form within 31 days of your Eligibility, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

If you do not enroll a person (including yourself) for dental coverage within 31 days or at open enrollment, and you enroll thereafter, coverage under this Plan will be limited. See your Booklet.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have signed the form to enroll. Also, in order to be sure coverage is in force for any new dependents you acquire, you should report any changes. If you don't sign and return your form within 31 days of your Eligibility, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:
 - the person was covered under other "creditable coverage" as defined below; and
 - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:
 - of termination of employment in a class eligible for such coverage;
 - of reduction in hours of employment;
 - your spouse dies;
 - you and your spouse divorce or are legally separated;
 - such coverage was provided under a CONTINUATION OF COVERAGE provision and such continuation was exhausted; or
 - the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A child who meets the definition of a dependent, but you elect it later in compliance with a court order requiring you to provide such coverage for your dependent child. Such coverage will become effective on the date specified by your Employer. Any limitation as to a preexisting condition may apply.
- A spouse, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

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- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
 - Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable. Unless otherwise stated in your Booklet, all provisions apply to Medical Expense Coverage and Comprehensive Dental Expense Coverage, except the Conversion Privilege section.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage (After Applicable Copay)

100% as to Preferred Pharmacy in the United States
(including Mail Order Pharmacy)*

**Mail Order Pharmacy only mails to locations in the United States.*

Amount of Copay Per Prescription or refill	Application of Copay (365 day maximum supply)
Generic Drugs \$ 10	<i>One Copay for each 31 day supply (12 Copay maximum)</i>
Brand Name Drugs \$ 20	<i>One Copay for each 31 day supply (12 Copay maximum)</i>

Note: All Non-Preferred Pharmacy expenses are payable under and subject to the terms of the Medical Expense Coverage section of this Plan.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

Certification Requirement For Care Received In The United States

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.
Excluded Amount \$ 400

This Excluded Amount applies separately to each type of admission and care listed above.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." Call the Customer Service number on your Aetna Bermuda I.D. card for information regarding Preferred Care Providers in the area of the United States in which you will be seeking care.

Any charge for a service or supply furnished by a Preferred Care Provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts

Individual and Family Calendar Year Deductibles are fixed amounts that each employee or family member must pay before the plan will pay most benefits. Flat dollar copays and benefit penalties do not apply toward meeting the calendar year deductible.

Non-Preferred Care Calendar Year Deductible \$ 300

When Covered Medical Expenses applied against a person's Calendar Year Deductible in any calendar year equal \$ 100, the Calendar Year Deductible will not apply to preferred care or other health care (including care received outside the United States) during the rest of that calendar year. Covered Medical Expenses incurred during the rest of that calendar year for preferred care and other health care will not be applied against the person's Calendar Year Deductible.

Non-Preferred Care Family Deductible Limit \$ 900
 If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal \$ 300, the Calendar Year Deductible will not apply to expenses incurred for preferred and other health care (including care received outside the United States) during the rest of that calendar year for you and your dependents.

The Calendar Year Deductible applies to all expenses except:

- Vision Eyewear Expenses
- Global Emergency Assistance Program

Inpatient Hospital Deductible \$ 250

However, for a confinement of a well newborn child that starts on the day of birth, this Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

This Inpatient Hospital Deductible applies to all Inpatient Hospital Expenses, except those incurred for Preferred Care.

Payment Percentage

The Payment Percentage applies after any deductible amounts.

*For Hospital Expenses**

Preferred Care (In U.S.)	Non-Preferred Care (In U.S.)	Other Health Care (In U.S.)	Care Received Outside the U.S.
90%	70%	80%	90%

* Emergency Room Treatment (Emergency Care), as defined in your Booklet, will be covered at the Preferred Care Rate (applies only in the United States).

For Physicians Fees

Preferred Care (In U.S.)	Non-Preferred Care (In U.S.)	Other Health Care (In U.S.)	Care Received Outside the U.S.
Non-surgical Office Visits - 100% after a \$ 10 copay	70%	80%	90%
Other - 90%	70%	80%	90%

Physicians Fees for Routine Eye Exam Expenses

Preferred Care (In U.S.)	Non-Preferred Care (In U.S.)	Other Health Care (In U.S.)	Care Received Outside the U.S.
Non-surgical Office Visits - 100% after a \$ 10 copay	100%	80%	100%
Other - 90%	70%	80%	90%

For Routine Physical Exam Expenses

Refer to applicable category of "*Physician Fees*" above.

For Hospice Care Expenses

For hospital charges refer to the applicable category of "*Hospital Expenses*" above.

For charges of a physician, refer to the applicable category of "*Physician Fees*" above.

For all other charges 80% *

Physicians Fees for Routine Hearing Exams

Preferred Care (In U.S.)	Non-Preferred Care (In U.S.)	Other Health Care (In U.S.)	Care Received Outside the U.S.
Non-surgical Office Visits - 100% after a \$ 10 copay	70%	80%	90%
Other - 90%	70%	80%	90%

For Other Covered Medical Expenses

100% as to:

National Medical Excellence Travel and Lodging Expenses (*applies only in the United States*)

Global Emergency Assistance Program

90% as to care received outside the United States:

Convalescent Facility Expenses

Home Health Care Expenses

All Other Medical Expenses for which a Payment Percentage is not otherwise shown

80%* as to care received in the United States:

Convalescent Facility Expenses

Home Health Care Expenses

All Other Medical Expenses for which a Payment Percentage is not otherwise shown

(*including prescription drugs dispensed by a non-preferred pharmacy and pharmacies located outside the United States*)

* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

Home Health Care agencies;

Diagnostic laboratories;

Durable Medical Equipment suppliers;

Ambulance services.

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

Reduced Payment Percentage

50% as to:

Non-emergency care in an emergency room in the United States.

Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders

Alcoholism, Drug Abuse, and Mental Disorders

Preferred Care (In U.S.)	Non-Preferred Care (In U.S.)	Other Health Care (In U.S.)	Care Received Outside the U.S.
Inpatient Treatment: 90%	70%	80%	90%
Outpatient Treatment: 80%	80%	80%	80%
Special Combined Inpatient Calendar Year Maximum Days		30	
Special Combined Outpatient Calendar Year Maximum Visits		20	

Payment Limits

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

It does not apply to expenses incurred for Outpatient Prescription Drugs.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 500 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 1,500, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 1,500 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 4,500, then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Period	The first 120 days of convalescent facility confinement.
Home Health Care Maximum Visits	120
Hospice Care	
Maximum Number of Days	30
Outpatient Maximum	\$ 5,000

Private Duty Nursing Care Maximum Shifts	70 per calendar year
Spinal Disorder Treatment Calendar Year Maximum	\$ 1,000
National Medical Excellence (<i>applies only in the United States</i>) Lodging Expenses Maximum	\$ 50.00
Travel and Lodging Maximum	\$ 10,000
Global Emergency Assistance Program Calendar Year Maximum	\$ 500,000
Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit	\$ 1,000,000

Pregnancy Coverage

Health Expense Coverage: Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Comprehensive Dental Expense Coverage

Calendar Year Deductible	\$ 50
The Calendar Year Deductible applies to all expenses except Type A Expenses.	
Family Deductible Limit	\$ 150
Payment Percentage	
Type A Expenses	100%
Type B Expenses	80%
Type C Expenses	50%
Calendar Year Maximum	\$ 1,500

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet will be provided under Aetna Life & Casualty (Bermuda) Ltd., policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET**

CONTINUATION OF COVERAGE UNDER FEDERAL LAW

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances. NOTE: This period of continuation shall be reduced by any periods of coverage provided through any furlough or other continuation or extension provisions included under your Plan that immediately precede the election of the Continuation of Coverage under Federal Law. In no event shall the total period of continuation under the Plan exceed the period of continuation which is allowable under the Continuation of Coverage Under Federal Law provision.

You and your dependents may continue any health expense coverage then in effect, without having to submit evidence of good health, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents will be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to an individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month. Whether coverage would terminate for reasons specified in sections A or B below, the cost to the Plan will be determined based on a rate level associated with similarly situated individuals residing inside or outside the U. S.

Subject to the payment of any required contributions, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work.

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your employer informs you or your dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur.

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if, prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with Section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any

family member (employee or dependent) of the disabled individual for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.

- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage will be available to you under another plan sponsored by your Employer.
- The date the individual fails to pay any required contribution.
- The first day after the date of the election that the individual is covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare.
- The month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the individual whose coverage is being continued for a 29-month period is no longer disabled.

B. Continuation of Coverage Under Other Circumstances

If a dependent's coverage would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to medical coverage. However, continued coverage will be available to your dependents under another plan sponsored by your Employer.
- The date the dependent fails to pay any required contribution.
- The first day after the date of the election that the dependent is covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

C. Multiple Qualifying Events

If coverage for you or your dependents is being continued for up to 18 months under section A, and during this 18-month period one of the qualifying events under the above section B occurs, this 18-month period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents who were added after the date continued coverage began.

D. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence

of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

E. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

F. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

AETNA GLOBAL BENEFITS® PREFERRED PROVIDER ORGANIZATION (PPO) HIGHLIGHTS -- "How Will This Affect Me?"

A Preferred Provider Organization (PPO) arrangement has been introduced to your plan of benefits, sponsored through Aetna Life & Casualty (Bermuda) Ltd., for care that is received in the United States.

What Is A PPO?

A PPO is a group of hospitals, physicians and other health care providers who agree to provide health care services at pre-negotiated rates to plan participants. Under a PPO, you and your dependents are free to receive services from any health care provider you wish. However, when you use health care providers who belong to Aetna's PPO network (preferred providers) you will receive a higher level of benefits (as described in your Summary of Coverage). When you use providers who do not belong to the Aetna network (non-preferred providers) you still receive benefits, but at a lower level (as described in your Summary of Coverage).

How Do I Locate A Preferred Provider?

You may obtain a selection of preferred providers in a specific area in the U.S. in which you intend to seek care or verification of a U.S. provider's participation in our network by calling the Customer Service phone number included on your Identification Card.

Why Should I Use A Preferred Provider?

In addition to higher benefit levels, using preferred providers offers other advantages as well. If you or your dependents receive care within the PPO network, the preferred provider takes care of filing claims and initiating any required precertification requirements. In addition, deductibles and payment limits are lower when care is provided by a preferred provider. This means you and your dependents pay less out of your own pockets for health care when care is received through a preferred provider.

Aetna's networks offer claim cost management programs that help make it possible for you and your dependents to receive care that's medically necessary, appropriate to the condition being treated, and provided in the most appropriate, cost-effective setting.

Aetna provides telephonic access to customer services and utilization management employees, from whom you can receive the help and information you may need to understand your benefits, use them wisely and make well informed healthcare decisions for you and your family.

You can call Customer Service for:

- Help with precertification and other utilization management programs,
- Answers to general health-related questions,
- Information about plan benefits, coverages and provisions, and
- Answers to questions about claim status and benefit payment.

Utilization Management is carried out through a group of programs that promote the appropriate, efficient use of health care resources before, during and after treatment.

This means helping to make sure that health care providers are doing what is best for the patient (you or your dependent) in the most cost-effective way possible. This can be accomplished through a variety of programs including: National Medical Excellence, Precertification, Focused Psychiatric Review, Telephonic Concurrent Review/Discharge Planning, and Individual Case Management.

National Medical Excellence: (applies only in the United States)

Aetna's National Medical Excellence (NME) program takes medical management into the realm of specialty care by matching up a patient needing a transplant with a nationally renowned facility with a proven track record for performing that procedure.

Precertification:

Precertification reviews the medical necessity, duration and setting of a hospital, licensed treatment facility or convalescent stay as well as outpatient private duty nursing, home health or hospice care. The precertification process starts with a call to our dedicated Tampa Claim Office, initiated by a preferred provider (or by the patient when care is received from a non-preferred provider).

Focused Psychiatric Review:

The Focused Psychiatric Review (FPR) program reviews psychiatric admissions, which includes exploring options for more cost-effective psychiatric and substance abuse treatment. The program gets Aetna case managers involved in a patient's care as early as possible, either before he or she is admitted to the hospital or within 48 hours of admission. The case manager works with the patient's therapist to establish treatment needs, goals and strategies.

Telephonic Concurrent Review/Discharge Planning:

Telephonic Concurrent Review recognizes the fact that hospital expenses are best managed during a patient's stay. Through the program, a nurse consultant from our Tampa Claim Office makes daily calls to hospitals where you or your dependent is confined. During these telephonic "visits", the nurse reviews patient records to ensure that hospital days and services are medically necessary and appropriate.

Individual Case Management (ICM):

Individual Case Management (ICM) matches a patient's needs with available community resources in complicated, chronic or long-term cases such as trauma, multiple sclerosis or cancer. As part of this process, an Aetna ICM nurse works with the employer, patient and doctor to find a more cost-effective, comfortable setting for care. Options can include hospice care, home care or specialized treatment facilities.

Utilization Management Standards

Once treatment has been rendered, "outcome" information (ie; diagnosis, treatment, prognosis, etc) is gathered and measured against Aetna's Utilization Management standards. Aetna has accumulated a body of treatment and outcome data second to none in the industry. The volume, diversity and wide geographic range of this information enables us to keep our network providers up-to-date on the latest, most efficient and effective treatments.

Quality

Aetna recruits providers whose practice patterns demonstrate quality, cost effective medicine. We review and verify their professional credentials and profile their utilization patterns. We then supply these providers with access to the most up-to-date, efficient and effective treatments for conditions as reflected in the UM standards that we define through our analysis of "outcome" information after treatment.

Summary

If you or your dependents intend to seek care within the United States, you will be eligible for a higher level of benefits if you use an Aetna preferred provider. A selection of preferred providers can be obtained by calling the Customer Service number on your Identification Card. If you or your dependents seek care through a preferred provider, the preferred provider will take care of fulfilling your Plan's precertification requirements and filing your requests of benefit payment. Payment will be coordinated between Aetna and the provider (other than any required Deductible and Out-of-Pocket amounts) and you will not be subject to any additional amounts over the negotiated fees. Utilization of Aetna's preferred providers also offers you access to quality programs and providers that promote the latest, most efficient and effective treatments.

GLOBAL EMERGENCY ASSISTANCE PROGRAM

One call, one standard for managing emergencies while traveling abroad

Aetna Global Benefits has established a strategic relationship with MedAire, Inc. to provide international travelers with access to global emergency assistance resources that are available through a single call to MedAire's Global Response Center (GRC). The GRC is available 24 hours a day, 7 days a week. The GRC provides access to registered nurses and U.S. board-certified physicians and specialists as appropriate. MedAire provides through the plan for the following:

- **Emergency Medical Evacuation:** An evacuation may be necessary if you or your eligible dependents develop an emergent medical situation requiring immediate attention and adequate medical facilities are not locally available. The GRC will coordinate and the plan will cover payment of medically supervised evacuations to the nearest facility capable of providing appropriate care.
- **Transportation After Initial Evacuation:** Following emergency medical evacuation and stabilization, the GRC will coordinate travel arrangements and a plan-paid, one-way economy airfare to you or your dependent's permanent residence or if appropriate to a health care facility nearer to the permanent residence. If requested, the plan will pay for medically necessary supervised return to the point of origin following emergency medical evacuation and stabilization.
- **Confinement Visitation:** The GRC will coordinate travel arrangements and a plan-paid economy round-trip air fare to the place of hospitalization at the evacuation destination for the person chosen by you or your eligible dependent if you or your eligible dependents are abroad or traveling alone and are hospitalized for more than 7 days following an emergency evacuation coordinated by the GRC.
- **Return of Dependent Children:** The GRC will coordinate travel arrangements and a plan-paid one-way economy air fare to your child's permanent residence when left unattended as a result of your accident or illness. A qualified attendant will also be provided, if required.
- **Repatriation of Mortal Remains:** The GRC will coordinate obtaining the necessary clearances for cremation or the return of your or your eligible dependent's mortal remains in the event that you or your eligible dependent die while abroad, including coordination and plan-payment of expenses associated with cremation or preparation and return of remains.

MedAire also provides for the following:

- **Medical Referrals:** When a medical situation requires local medical attention, the GRC can provide referrals to the most appropriate, nearby medical care resources, including preferred access to Aetna's network of medical providers and MedAire's network of Global Doctor clinics. Care is monitored by the GRC, and, as a part of the plan, is available for second opinions and additional consultation subsequent to any local care visits.
- **Emergency Medication, Vaccine, and Blood Transfers:** The GRC will coordinate dispatching of medications, vaccines or blood upon the prescribing physician's authorization (if legally permissible). You or your eligible dependent will be responsible for any medication, vaccine, or blood and transportation costs.
- **Hospital Deposit & Emergency Cash Advance:** The GRC will coordinate wire transfer or other guarantee of payment or any required emergency hospital admittance deposit, and, in the event of an emergency, the coordination of a cash advance of your or your eligible dependents' funds, provided the GRC has secured payment from you or your eligible dependents or has obtained your or your eligible dependents' guarantee to reimburse the GRC.
- **Legal Referral Assistance:** If local legal assistance is necessary, the GRC will identify attorneys as well as assistance in securing Bail Bonds or other legal instruments, should you or your eligible dependents require legal aid. You or your eligible dependents would be responsible for any contracted legal fees.
- **Translation Services:** The GRC provides immediate translation assistance or referrals to local interpreter services.

NOTE: All evacuations, returns to residence after stabilization, and/or repatriations of mortal remains are coordinated by and subject to the prior approval of the Global Response Center.

How To Take Advantage of Your Assistance Service Benefits:

Call the Global Response Center (GRC) at 1-877-242-5580 if you or your eligible dependents:

- have a medical concern or question;
- are hospitalized or are about to be hospitalized;
- are involved in an accident requiring medical treatment;
- are having difficulty locating medical care;
- require translation services; or
- have other serious difficulties while located abroad.

If the condition is an emergency, you or your eligible dependents should go immediately to the nearest physician or hospital without delay and then contact the GRC. While Aetna Global Benefits and MedAire's Global Response Center will do everything reasonably possible to provide or direct you or your eligible dependents to the most appropriate care available once a call has been initiated, they are not responsible for the availability, quantity, quality or result of any medical treatment you may receive, or your failure to obtain medical treatment.

The GRC is available 24 hours a day, 7 days a week, 365 days a year using the same telephone number from anywhere in the world.

You or your eligible dependents must always provide your Policy name and number and your name and Identification Number as the individual through which this group coverage has been made available. If you are not the individual seeking assistance, your eligible dependents must also provide their name.

The nature of the illness, injury, medical problem or emergency in question and the type of help that is needed should be explained to the GRC.

If appropriate, a registered nurse and/or a U.S. board-certified physician will try and assist you with your immediate situation. If local care is needed, the GRC will provide a referral to the most appropriate and available medical facility, physician or assistance service provider.

When local medical care is needed, the GRC will monitor your or your eligible dependent's medical progress. If needed, and with your consent, the GRC can also maintain communications with your family physician, your family and your employer (as may be required). If a medical evacuation and/or medical repatriation are deemed necessary, the GRC will coordinate all transportation and medical needs from the originating hospital to the final destination facility.

Expenses Not Covered Under the Global Emergency Assistance Program:

The Global Emergency Assistance Program shall not be responsible for the cost of services or expenses arising from:

- Your or your eligible dependents' suicide, attempted suicide, or willful self-inflicted injury, sexually transmittable diseases, or the abuse of drugs or alcoholic drink;
- Your or your eligible dependents' taking part in military or police service operations;
- The commission of or attempting to commit an unlawful act; or
- Aviation, except where you or your eligible dependents fly as a passenger in an aircraft properly licensed to carry passengers (except the Military Aircraft Command of the United States or similar air transport service of other countries.)
- You or your eligible dependents:
 - * traveling against the advice of a physician;
 - * traveling for the purposes of obtaining medical treatment; or
- Non-emergency expenses for routine or minor medical problems, tests, and exams where there is no clear or significant risk of death or imminent serious injury or harm to you or your eligible dependents.
- A condition which would allow for treatment at a future date convenient to you or your eligible dependents and which does not require emergency evacuation.
- Incidental expenses, including but not limited to, accommodations and meals incurred in connection with an emergency evacuation.

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- Local emergency transportation expenses, including ground ambulance fees for you and your eligible dependents' initial transportation to local hospitals.
 - Mountaineering or rockclimbing necessitating the use of guide ropes, potholing, ballooning, motor racing, speed contests, skydiving, hang gliding, parachuting, spelunking, heliskiing, extreme skiing or bungee cord jumping, deep sea diving utilizing hard helmet with air hose attachments, racing of any kind other than on foot and all professional sports.

Failure to contact GRC in a timely manner may invalidate your eligibility for payment of transportation expenses. In addition, if the evacuation method or destination goes outside the boundaries of this program description, it may invalidate payment of subsequent transportation expenses.

Any bills incurred by you or your eligible dependents relating to assistance services authorized by the GRC must be received by MedAire in order to obtain payment consideration.

Note: As used throughout this section, the term "emergency" shall be defined to mean a situation when, in the professional opinion of the Global Response Center, a clear and significant risk of death or imminent serious injury or harm to you or your eligible dependents exists.

INFORMED HEALTH[®] Line

A nurse-facilitated health information service designed to help you become a better health care consumer

Arrangements have been made with Informed Health, Inc., an Aetna, Inc. subsidiary company that offers an information service to assist people like you in becoming better consumers of health care. The service, Informed Health Line (IHL), provides you and your eligible dependents with toll-free*, 24-hour access to credible health information. You can either:

(Alternative 1:) Speak to an experienced, U.S.-based, registered nurses who can:

- Answer questions about health concerns
- Provide current, easy to understand information on a wide-range of health issues such as:
 - common prevention strategies
 - chronic conditions; and
 - complex medical situations
- Discuss options for seeking medical attention
- Help you and your eligible dependents prepare for appointments with your providers

To assist multi-lingual callers, registered nurses have access to AT&T's language translation service.

(NOTE: Informed Health nurses cannot diagnose, prescribe, or give medical advice.)

(Alternative 2:) Access an audio health library from any touch-tone phone, 24 hours-a-day. The audio health library, which is available in either English or Spanish, offers you and your eligible dependents increased flexibility by allowing you to choose how you access the health information you need. You can decide to speak to a nurse right away or go directly to the audio health library which contains information on thousands of health topics including common conditions and diseases, gender and age-specific health issues, mental health/ substance abuse, weight loss and much more. Information for the particular conditions specified will be made available through the Audio Health Library by entering a four-digit code that corresponds to the condition.

Advantages of IHL:

Informed Health Line offers useful information to educate you and your eligible dependents about a variety of health topics; increase your awareness and understanding of important health issues; and help you to more effectively communicate with your providers.

For you and your eligible dependents: The IHL service offers 24-hour access to health information provided by qualified U.S.-based professionals, as well as supplemental written materials. These tools may help empower you to actively participate in your care and may help improve the effectiveness and efficiency of that care.

For example, information provided by Informed Health Line nurses may help you identify problems to your physicians that might otherwise be ignored, thus leading to early treatment of potentially serious and costly health conditions.

For primary care physicians: The IHL service can provide powerful ancillary support by facilitating more effective communications with better informed and well prepared patients.

For employer groups & plan sponsors: IHL services can provide a means to increase your satisfaction with employers or others administering your health benefits and assist you in making more effective and efficient use of covered services.

For health plans: IHL services can provide a means to increase your satisfaction with your health plans and help you make more effective and efficient use of covered services.

How You Can Take Advantage of Informed Health Line Services:

You may receive:

- a convenient AT&T wallet card that provides the toll-free* telephone number through which health information services can be accessed;
- a welcome flyer that provides an overview of the services available through Informed Health;
- information from on-line medical databases and journals (mailed to you upon request); and access to round-the-clock, toll-free*, confidential health care information.

Both the Audio Health Library and the Service's U.S.-based registered nurses are available 24 hours a day, 7 days a week.

You or your eligible dependents can call the toll-free* number that has been provided.

NOTE: Neither Aetna Global Benefits nor Informed Health is a healthcare provider and neither shall be responsible for the availability, quantity, quality, or result of any medical treatment a member may receive, or for a member's failure to pursue or obtain medical treatment.

- *Toll-free calling is available in much of the world. Refer to your Plan's AT&T Wallet Card for available locations.*

On-line Global Health and Travel Information from HTH Worldwide

Through an arrangement with HTH Worldwide (known as “HTH”), AGB can now offer you and your eligible dependents access to useful information specifically designed to help global employees and their families research and pursue quality health care virtually anywhere in the world. HTH is a leading provider of web-based health and travel information and services that are specifically tailored to help address the global needs of individuals living, working and traveling outside their home country.

By visiting the AGB Member website <http://www.aetna.com/agb> you and your eligible dependents can access a suite of self-service, web based tools that may help you to be more self-reliant and better prepared for health related issues you may encounter during your overseas assignment. See the “Global Health and Travel Information” section of the Welcome Letter in your Member Kit or contact your Plan Sponsor for instructions on how to access the HTH Services that are applicable to your plan of benefits.

Through AGB’s online Member Service Center, you will have access to the important resources described in the following section(s).

What Types of Resources Are Available Through HTH?

Provider Community

International Provider Community – A community of over 2,500 English-speaking, pre-identified physicians, dentists, psychologists and other allied health professionals who are located in over 120 countries and who represent 24 medical specialties recognized by the American Board of Medical Specialties.

Providers are selected based on their professional qualifications, clinical experience, hospital affiliations, language skills, continuing medical education, peer recommendations, and positive experience with expatriate patients. Hand-selected providers must also have one of the following: verified current American Board of Medical Specialties certification; verified current Royal Medical or Surgical College membership (from the United Kingdom, Ireland, Canada, Australia, or New Zealand); and/or recommendation by HTH Regional Physician Advisors (RPA), HTH Medical Staff, and/or HTH Recruitment Partner.

In addition to professional qualification information, provider profiles also include ancillary details, which are verified 6 times annually, such as:

- Practice address and contact details
- Email address
- Language(s)
- Special Services (house calls, ambulance, onsite lab)
- Hospital Affiliations

Interactive/Online Tools

Provider search tool – This utility allows you to conduct a personalized on-line search of HTH’s International Provider Community to identify and research physicians and other providers that meet your geographic and medical specialty criteria. A convenient link is also provided to Aetna’s DocFind search engine, which provides information about the broad network of Aetna providers across the United States.

Health and Security Information

CityHealth Profilessm - Information on the healthcare services in the world's most frequent destinations for international assignees and business travelers. Valuable information that includes, but is not limited to the following, is presented at both a city and country level for more than 200 destinations outside of the United States:

- **Notable hospital profiles** – key facilities are profiled based upon their location, clinical services, track record of quality service, medical staff, equipment, accessibility for international patients and recommendations from HTH's network of 90+ Regional Physician Advisors.
- **Health risks & vaccination recommendations**
- **Pharmacy Information** – reliability, typical hours, etc
- **Local Health System information**
- **Currency Converter & Local time**
- **U.S. & Foreign Embassy contact details**
- **Fire, Police, & Ambulance Emergency Numbers**
- **Telephone Dialing Codes**

Health System Profiles provides a unique and succinct evaluation of the health system of many commonly visited countries. Such profiles address critical points of interest, including health insurance and financing issues, hospital and physician access, and quality of care.

Health News and Security Information – Critical health and security news from around the world, including disease outbreak information, travel advisories and public announcements from the U.S. State Department. Available security report topics include:

- Country & city overviews
- Cultural tips
- Security situation(s), including hijacking & kidnapping risks
- Crime, including terrorism & street crime(s)
- Political Stability, including demonstration(s)
- Police and Fire Safety
- Airport, Airlines & Hotels and Ground Transportation Information
- Communications

Translation Guides – Annually updated, interactive tools that allow you to:

- **Drug Translation Guide** – select the brand names of prescriptions and over-the-counter medications you may use in your home country to determine their local generic equivalent name and whether they are available in your host country. The Drug Translation Guide, which supports country-specific brand/generic drug name(s) and preparation(s) in 21-plus frequently visited countries, can also be used to identify the name(s) of the local manufacturer(s)/distributor(s) of such medications, as well as the locally used generic or brand name(s) and formulations for the product.
- **Medical Terms and Phrases** –get translations of commonly used medical terms and phrases from your native language into the language of the country where you are traveling or living. The Medical Terms and Phrases tool contains translations for more than 600 commonly used technical and layperson medical terms in, including but not limited to, English, French, German, Spanish, Portuguese, and Italian. Additionally, Chinese, Japanese, and Russian are available in PDF format.

The Medical Terms translation tool provides assistance in translating names of diseases and medical conditions, body parts, medical equipment, diagnostic tests and procedures.

The Medical Phrases translation tool provides assistance in helping patients to express their symptoms, needs and questions to hospital staff or pharmacy personnel who may not possess the same degree of English fluency as the physicians.

News and Features

- **Healthy Travel/Life Abroad Feature Articles** – Feature length articles written for expatriates and business travelers by HTH Worldwide staff and medical advisors. Sample topics include managing jet lag, avoiding traveler’s diarrhea, and traveling safely with chronic illnesses such as diabetes. The Travel Health Center articles fit into four general categories: “Expatriate Travel Health”, “Business Travel Health”, “General Travel Health”, and “Special Needs Travel Health.”

Customer Support Services 24 hours a day

If you have any questions about the AGB Member website or if you require assistance using any of the tools, please call the AGB Member Service Center at the number shown on your Identification Card, 24 hours a day, 7 days a week.

Toll free calling is available in much of the world. Please consult the AT&T Wallet Card included in your Welcome Kit or go to http://www.att.com/business_traveler/guides_and_access/international_dialing.html to find the access numbers for your country.

Note: Neither HTH Worldwide nor Aetna Bermuda is a healthcare provider and neither shall be responsible for the availability, quantity, quality or result of medical treatment you or your eligible dependents may receive or for your failure to obtain medical treatment.